**Joint Committee on Administrative Rules**

ADMINISTRATIVE CODE

**TITLE 89: SOCIAL SERVICES**
**CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**
**SUBCHAPTER b: ASSISTANCE PROGRAMS**
**PART 120 MEDICAL ASSISTANCE PROGRAMS**
**SECTION 120.388 PROPERTY TRANSFERS OCCURRING ON OR AFTER JANUARY 1, 2007**

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**Section 120.388 Property Transfers Occurring On or After January 1, 2007**

The provisions in this Section are intended to comport with federal requirements related to transfers of assets, in particular, requirements under 42 USC 1396p and guidance from the US Department of Health and Human Services related to those statutory requirements. Interpretation and application of this Section shall be made in light of those requirements.

a) General. A transfer of assets for less than fair market value made on or after January 1, 2007 by an institutionalized person or the spouse of that person within 60 months before the later of applying for medical assistance or transferring an asset shall result in a period of ineligibility for long term care services for that person.

b) Long term care services are defined as:

1) services provided in a long term care facility as that institution is defined in Section 120.61(a); and

2) services provided under a home and community based waiver authorized under 42 USC 1396n(c) or (d) and specified in 42 CFR 441 Subpart G or H.

c) Institutionalized individuals or persons are defined as:

1) persons residing in long term care facilities, including those who were residing in the community at the time a transfer of assets was made; or

2) persons who, but for the provision of home and community based waiver services (42 USC 1396a(a)(10)(A)(ii)(VI)), would require the level of care in a long term care facility, including those persons receiving home and community based waiver services who were not receiving the services at the time a transfer of assets was made.

d) Assets.

1) For purposes of this Section, the term "assets" or "property" includes all income (as defined in 42 USC 1382a) and resources (as defined in 42 USC 1382b, except subsection (a)(1) of that section, which excludes the home as a resource) of an institutionalized person and that person's spouse, including, but not limited to: cash; savings certificates; stocks; bonds; interests in real property, including mineral rights; rights to inherited real or personal property or income; and accounts and debts receivable.

2) Assets also include any income or resources that the person or the person's spouse is entitled to but does not receive because of action or inaction by:

A) the person or the person's spouse;

B) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse;

C) any person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse; or

D) any person who acted (or failed to act) to avoid receiving assets to which the person was entitled.

3) Examples of actions that would cause assets not to be received include:

A) Irrevocably waiving pension income;

B) Waiving the right to receive an inheritance;

C) Not accepting or accessing injury settlements;

D) Arranging for a defendant in a civil action to divert a settlement amount into a trust or similar device for the benefit of the person, who is a plaintiff in the case;

E) Refusing to take legal action to obtain a court-ordered payment that is partially or wholly unpaid, such as alimony; or

F) Receiving an inheritance under a will when renouncing the will and taking a statutory share (see 755 ILCS 5/2-8) is more advantageous. Alternately, renouncing a will and taking a statutory share when taking the inheritance is more advantageous.

4) Failure to take action to receive an asset is not considered a transfer for less than fair market value when evidence is submitted showing the cost of obtaining an asset exceeds the value of the asset.

e) Transfer. A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property

or changes (e.g., a change from joint tenancy to tenancy in common) the way property is held.

1) Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described in Section 120.380(i) and 89 Ill. Adm. Code 113.140(e)).

2) Transactions involving annuities, including the purchase of an annuity or any action by a person that changes the course of payments to be made by the annuity or the treatment of income or principal of the annuity, are considered transfers under this Section. Such actions include, but are not limited to, additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and any action intended to make an annuity irrevocable or nonassignable.

3) For property held in joint tenancy, tenancy in common or similar arrangement, a transfer occurs when an action by any person reduces or eliminates the person's ownership or control of the property.

4) A transfer of income in the month it is received is considered a transfer of assets if the income would have been considered an asset in the following month as provided under Section 120.380(d)(1). A transfer of the proceeds of a loan in the month received is considered a transfer of assets.

f) Fair market value (FMV) is an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred. Prevailing price is what property would sell for on the open market between a willing buyer and a willing seller, with neither being required to act and both having reasonable knowledge of the relevant facts.

1) In determining if FMV has been received for an asset, the Department shall use all reasonable means available and consider all relevant facts and circumstances relating to the asset and the transaction, including, but not limited to: the cost or price paid for the asset, whether the transaction was at arm's length, comparable sales, replacement cost, and expert opinion. In determining the FMV of farmland in Illinois, the Department may take into account market values determined under methodologies developed by the University of Illinois College of Agricultural, Consumer and Environmental Sciences.

2) For an asset to be considered transferred for FMV, the compensation received for the asset must be in a tangible form with intrinsic value that is roughly equivalent to or greater than the value of the transferred asset.

3) Transfers of assets for "love and affection" are not considered transfers for FMV. A transfer to a friend, family member or relative for care provided for free in the past is a transfer of assets for less than FMV. The Department presumes that services, care or accommodations rendered to a person by a friend or family member are gratuitous and without expectation of

compensation. This presumption may be rebutted by credible documentary evidence that preexists the delivery of the care, services or accommodations showing the type and terms of compensation and contemporaneous receipts, logs or other credible documentation showing actual delivery of the care or services claimed. Compensation paid in excess of prevailing rates for similar care, services or accommodations in the community shall be treated as a transfer for less than FMV.

4) "Compensation received" is the amount of money or value of any property or services received in return for the institutionalized person's assets. The compensation received may be in the form of:

A) Cash;

B) Other assets such as promissory notes, stocks, bonds, and both real estate contracts and life estates that are evaluated over an extended time period;

C) Discharge of a debt;

D) Prepayment of a bona fide and irrevocable contract, such as a mortgage, shelter lease, loan or prepayment of taxes;

E) Services; and

F) Any other act, object, service or other benefit that has tangible or intrinsic economic value to the person.

5) The term "uncompensated value" means the difference between the FMV of a transferred asset (less any outstanding loans, mortgages, or other encumbrances on the asset) and the actual compensation received. Only the uncompensated value of a transferred asset is subject to the penalty provisions described in this Section.

g) Look Back Period. The provisions of this Section apply to any asset transfers occurring on or after January 1, 2007, and before the date on which the person is an institutionalized person (as defined in subsection (c) of this Section) and has applied for medical assistance.

h) Penalty. If a person transfers assets for less than fair market value, the person is subject to a period of ineligibility for long term care services. The penalty period is determined in accordance with subsection (j) of this Section. If otherwise eligible, persons subject to a penalty remain eligible for all covered medical services except long term care services.

i) Penalty Period.

1) A penalty period under this Section:

A) begins with the later of:

i) the first day of a month during which a transfer for less than FMV is made; or

ii) the date on which the person is eligible for medical assistance and would otherwise be receiving long term care services (based on an approved application for those services) were it not for the imposition of the penalty period. A person is not considered eligible and services are not considered capable of being received under this subsection (i) until any spenddown is met; and

B) does not occur during any other period of ineligibility under this Section.

2) A notice of penalty period shall include a statement that the person may appeal the penalty period pursuant to 89 Ill. Adm. Code 102.80.

j) Penalty Calculation. A penalty period is determined based on the uncompensated value of transfers. The penalty period is calculated by dividing the total uncompensated value of assets transferred by the average monthly cost of long-term care services at the private rate in the community in which the person is institutionalized at the time of application. The result is the penalty period in number of months, days and portion of a day (e.g., $65,000/$4000 = 16.25 = 16 months and 7.5 days). The Department will not round down or otherwise disregard any period of ineligibility calculated under this subsection.

k) Multiple Transfers. Multiple, non-allowable transfers made during the look-back period shall be cumulated and treated as a single transfer. A single period of ineligibility shall be calculated based on the total uncompensated value of the transfers. Once a penalty period is imposed, it continues to run without regard to whether the person continues receiving long term care services.

l) When transfers by a community spouse result in a penalty period for the institutionalized spouse and the community spouse subsequently becomes institutionalized and is otherwise eligible for medical assistance, the Department shall divide any remaining penalty period equally between the spouses. If one spouse predeceases the other before the penalty period has ended, the remaining penalty period will be added to the surviving spouse's penalty.

m) A person shall not be subject to a penalty period under this Section to the extent that:

1) homestead property was transferred to:

A) the person's spouse;

B) the person's child who is under age 21;

C) the person's child who is determined blind (as described in Section 120.313) or determined disabled (as described in Section 120.314);

D) the person's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the person became institutionalized; or

E) the person's son or daughter who provided care for the person and who resided in the homestead property for the two years immediately prior to the date the person became institutionalized provided credible tangible evidence is presented that:

i) shows the person was in need of care that would have otherwise required an institutional level of care. The evidence may consist of a physician's statement or an evaluation conducted by a medical professional showing the need for an institutional level of care. A diagnosis of Alzheimer's or other dementia related illness shall be prima facie evidence of a need for an institutional level of care; and

ii) shows the son or daughter resided with the person for two years immediately prior to the person's institutionalization. The evidence may consist of tax returns, driver's license, cancelled checks or other documentation demonstrating residence in the home for at least two years prior to the parent's institutionalization; and

iii) shows the son or daughter provided care to the person that prevented institutionalization. The evidence may consist of sworn affidavit or statement signed by the son or daughter.

2) the transfer:

A) by the institutionalized person was to:

i) the person's spouse or to another person for the sole benefit of the person's spouse;

ii) the person's child or to a trust (including a trust described in Section 120.347(d)) established solely for the benefit of the person's child or to another person for the sole benefit of the institutionalized person's child. To qualify under this subsection (m)(2)(A)(ii), the child must be determined blind (as described in Section 120.313) or determined disabled (as described in Section 120.314);

iii) a trust (including trusts described in Section 120.347(d)(1) and (2)) established solely for the benefit of a person who is determined disabled (as described in Section 120.314).

B) "sole benefit of" a person means:

i) the transfer is arranged in such a way that no person or entity except the specified beneficiary can benefit from the property transferred;

ii) the transfer instrument or document provides for the spending of the funds involved for the benefit of the person on a basis that is actuarially sound, based on the life expectancy of the person involved (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration http://www.ssa.go/OACT/STAT/table4c6.html). Equal and periodic payments are not required. This subsection (m)(2)(B)(ii) does not apply to trusts described in Section 120.347(d) because those trusts provide for a "payback" to the State upon the death of the beneficiary;

iii) the transfer was accomplished via a written instrument of transfer (e.g., a trust document) that legally binds the parties to a specified course of action and clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document may not be said to have been made for the sole benefit of the person since there is no way to establish, without the document, that only the specified person will benefit from the transfer.

3) the person intended to transfer the property for fair market value (FMV). When a transfer is made for less than FMV, a person is presumed to have done so intentionally. This presumption may be rebutted by objective tangible evidence of the following (a subjective statement of intent or claim of ignorance of the asset transfer provision is not sufficient):

A) initial and continuing reasonable, good faith efforts to sell the property on the open market were made and that the compensation received was the best value offered;

B) a legally binding contract was executed that provided for adequate compensation in a specified form (e.g., goods, services, cash) in exchange for the transferred asset;

C) the person acted in good faith that he or she was receiving FMV or the best price for the item or property, and the item or property was

transferred to a person other than a related party (e.g., a person related by blood, marriage or friendship);

D) the person had other adequate means or plans for support, including medical care, at the time of the transfer.

4) the transfer was made exclusively for a reason other than to qualify or remain eligible for medical assistance. A transfer for less than FMV is presumed to have been made to qualify for assistance. This presumption may be rebutted by credible tangible evidence that the person or spouse had no reason to believe that Medicaid payment of long term care services might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition, such as a stroke or Alzheimer's disease, or a personal injury may provide convincing evidence that there was no reason to anticipate a need for long term care assistance. A subjective statement of intent or claim of ignorance of the asset transfer provision is not sufficient. Other examples of credible evidence showing a reason for transferring assets for reasons other than to qualify or remain eligible for medical assistance include, but are not limited to:

A) police reports, other related law or regulatory enforcement reports, documentation from the Department on Aging, or like credible evidence that assets were misappropriated as a result of elder or other abuse and cannot be recovered;

B) evidence that the transfer was made by a person lacking the mental capacity to make the transfer and who was not represented by a guardian, family member or other legal representative at the time of the transfer.

C) evidence that the transfers were for everyday living expenses, incidental gifts to family members, or contributions to charities or religious organizations made on a consistent basis over a period of time (not only in close proximity to applying for assistance). These expenses shall be reviewed taking into account the individual circumstances of a particular transfer and applying an objective standard based on whether a reasonable person would have made the transfer unmotivated by an intent to qualify for assistance; and

D) other evidence pertinent to the person's circumstances at the time of the transfer relating to:

i) the person's physical and mental condition;

ii) the person's financial situation;

iii) the need for medical assistance;

iv) any changes in living arrangements;

v) the length of time between the transfer and application for medical assistance; or

vi) whether unexpected events occurred between the transfer and application.

5) the person transfers property disregarded as a result of payments made by a qualified long term care insurance policy approved by the Director of the Illinois Department of Insurance under the Qualified Long Term Care Insurance Partnership (QLTCIP) program (50 Ill. Adm. Code 2012).

6) the assets transferred for less than FMV have been returned to the person.

A) For transfers occurring prior to January 1, 2012, if only parts of transferred assets are returned, a penalty period shall be reduced but not eliminated. For example, if only half the value of the asset is returned, the penalty period shall be reduced by one half.

B) For transfers occurring on or after January 1, 2012, all of the assets transferred for less than FMV must have been returned to the person. Full or partial returns occurring prior to imposition of a penalty reduce the uncompensated portion of the transfer by the amount returned. Once a penalty is imposed it may only be eliminated if all assets transferred for less than FMV are returned. When all transferred assets are returned, the assets are treated as returned on the date the penalty was imposed; the penalty is erased and the returned assets are treated as available as of the date the penalty was imposed. For the time period between imposition of the penalty and return of the assets, the Department will treat the assets as available to meet the spenddown obligation for that time period only (see Section 120.384). At the point in time that assets are in fact returned, they are treated as available assets that may be reduced by a spenddown obligation or otherwise. Returned assets that are transferred for less than FMV may be subject to penalty.

7) the Department determines that the denial of eligibility would cause an undue hardship as provided in subsection (r) of this Section.

n) The purchase of an annuity by or on behalf of an institutionalized person or the spouse of that person shall be treated as a transfer of assets for less than FMV unless:

1) the annuity names the State of Illinois as the remainder beneficiary in the first position for up to the total amount of medical assistance paid on behalf of the institutionalized person; or

2) the annuity names the State of Illinois in the second position after the community spouse or minor child or child with a disability and is named in

the first position if the spouse or a representative of the child disposes of any remainder for less than FMV.

o) The purchase of an annuity by or on behalf of an institutionalized person shall be treated as a transfer of assets for less than FMV unless:

1) the annuity is considered either:

A) an individual retirement annuity described in section 408(b) of the Internal Revenue Code (26 USC 408(b)); or

B) a deemed individual retirement account (IRA) under a qualified employer plan described in section 408(q) of the Internal Revenue Code (26 USC 408(q)); or

2) the annuity is directly purchased with proceeds from one of the following:

A) a traditional IRA described in section 408(a) of the Internal Revenue Code (26 USC 408(a));

B) certain accounts or trusts treated as traditional IRAs under section 408(p) of the Internal Revenue Code (26 USC 408(p));

C) a simplified employee pension described in section 408(k) of the Internal Revenue Code (26 USC 408(k)); or

D) a Roth IRA described in section 408A of the Internal Revenue Code (26 USC 408A); or

3) the annuity meets all the following requirements:

A) was purchased from a commercial financial institution or insurance company authorized under federal or State law to issue annuities;

B) is actuarially sound and based on the estimated life expectancy of the person (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/ table4c6.html). Period certain annuities that pay out over a term less than the person's expected life shall be treated as actuarially sound;

C) is irrevocable and nonassignable; and

D) pays benefits in approximately equal periodic payments no less than quarterly, with no deferred or balloon payments.

p) Life Estates. The purchase of a life estate interest in another person's home shall be treated as a transfer for less than FMV unless the purchaser resided in the home for at least 12 consecutive months after the date of the transfer. If the purchaser resided

in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than FMV.

q) Promissory Notes, Loans and Mortgages. The purchase of a promissory note, loan or mortgage by a person shall be treated as a transfer of assets for less than FMV unless the following conditions are met (a promissory note, loan, or mortgage that does not satisfy these conditions shall be valued based on the outstanding balance due the person under the instrument as of the later of the date of application for medical assistance or the date of the transfer):

1) a written instrument recording the transaction is executed, signed and dated on the effective date of the transaction;

2) the instrument provides for a repayment term that is actuarially sound (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/table4c6.html). Instruments that provide for a repayment term that is less than the person's life expectancy shall be treated as actuarially sound;

3) the instrument provides for payments to be made in equal installments (no less than monthly) during the term of the loan with no deferral and no balloon payments;

4) the instrument prohibits the cancellation of the balance upon the death of a lender;

5) a tangible, verifiable record of consistent, timely payments in the amounts provided under subsection (q)(3) demonstrates a good faith attempt to repay the instrument. Unpaid installments delinquent three months or more will result in the Department treating the amount remaining unpaid on the instrument as a non-allowable transfer; and

6) the instrument provides for the assignment to the State of Illinois, as of the date of death, of up to the total amount of medical assistance paid on behalf of the institutionalized person; the State shall be placed in the first position of assignment or in the second position after the community spouse or minor child or child with a disability, and is named in the first position if the spouse or a representative of the child disposes of any remainder for less than FMV.

r) Hardship Waiver.

1) The Department shall waive a penalty period or a portion of a penalty period if it determines that application of a penalty creates an undue hardship. An undue hardship exists when application of a penalty would deprive an institutionalized person:

A) of medical care, endangering the person's health or life; or

B) of food, clothing, shelter, or other necessities of life.

2) The person requesting a hardship waiver shall have the burden of proof that actual, not just possible, hardship exists. The Department may require the person to provide written evidence to substantiate the circumstances of the transfer, attempts to recover the uncompensated value of the transfer, reasons for the transfer and the impact of a period of ineligibility for long term care services. The following criteria shall be considered in determining whether a hardship waiver may be granted:

A) whether credible evidence is presented that the person, in good faith and to the best of his or her ability, has taken all equitable and legal means available to recover an asset or assets that have been transferred for less than fair market value. In cases involving alleged theft, fraud, elder abuse or other misappropriation of assets, evidence of referrals to the police or other law or regulatory enforcement agencies is required;

B) the medical condition, mental capacity, financial ability and other factors that may have affected the person at the time of the decision to transfer the assets for less than FMV;

C) the denial of assistance would force the person to move; and

D) subject to the availability of beds, the person would be prohibited from joining a spouse in a facility or from entering a facility that is in close proximity to his or her family.

3) Transfers Prior to November 1, 2011.
Notwithstanding the provisions of subsection (r)(2), and notwithstanding the January 1, 2012 implementation date of the look back period, for transfers occurring prior to November 1, 2011, a hardship waiver shall be granted if the applicant signs an attestation form stating that the penalized transfer was made in reliance on the administrative rules in effect at the time of the transfer and that, without a waiver, the person faces deprivation of the elements described in subsections (r)(1)(A) and (B).

4) A facility in which an institutionalized person is residing may request a hardship waiver on behalf of that person under this subsection (r) provided written consent has been obtained from the person if the person is legally competent to give that consent or from the person's personal representative, who may include the person who signed the application for medical assistance on behalf of the resident (see 89 Ill. Adm. Code 110.10(c)).

s) Records Production. The Department or its agent may request any and all records necessary to determine the existence and extent of any transfers of property under this Section. Persons are required to cooperate in providing requested information and verifications in accordance with Section 120.308. The Department will provide

any needed assistance requested by a person and will use reasonable measures requesting records, taking into account the age, significance, relevancy and difficulty of obtaining the records, the medical condition and mental capacity of the person, and other factors that may affect the person's ability to retrieve records.

t) Notice.

1) The Department shall issue a notice to any person who is subject to a penalty period not less than 10 days prior to imposition of the penalty. The notice shall inform the person of the period of ineligibility for long term care services and include a statement that the person may appeal the decision to impose a penalty period pursuant to 89 Ill. Adm. Code 102.80.

2) A notice of imposition of a penalty period shall inform the person that a hardship waiver under subsection (r) may be requested and that the person or facility in which the person resides may submit in writing (pursuant to subsection (r)(2)) evidence that a hardship exists. The evidence may be submitted to the Department, which shall review the information and, based on the criteria under subsection (r), determine whether a hardship waiver should be granted. Upon completion of its review, the Department shall issue a notice of decision on a request for a hardship waiver that shall include a statement that the person may appeal the decision pursuant to 89 Ill. Adm. Code 102.80.

(Source: Added at 35 Ill. Reg. 18645, effective January 1, 2012)

# PM 07-02-08-d: Prepaid Burial Contract Funded by Life Insurance

**WAG 07-02-08-d**

Disregard a prepaid burial contract funded by a life insurance policy when ownership of the insurance policy has been irrevocably assigned. With the irrevocable assignment of ownership of the insurance policy, the resource no longer belongs to the person.

When a life insurance policy funds a prepaid burial contract, the life insurance policy is purchased at the time the prepaid burial arrangement is made. The funeral home, acting as an agent of the insurance company, sells the person the life insurance policy. The person assigns ownership of the life insurance policy to a third party. The third party may be a trust within the insurance company. The party accepting the assignment of the life insurance policy is responsible for ensuring that the funeral home receives the proceeds of the insurance policy when they provide the funeral goods and services selected by the person.

The assignment represents the transfer of resources. If the person resides in an NH or SLF facility, or has applied for or is receiving DoA HCBS waiver services, determine if fair market value was received. The amount exempted is limited to the insurance benefit designated for the cost of funeral goods and services to be provided upon the person's death. The contract must include a complete description of funeral goods and services to be provided and the cost of those goods and services. Treat any amount not specified in the contract as a transfer for less than fair market value.

➧To be considered exempt, a burial plan established on or after 07/01/12, the trust that funds the burial must also state that, upon the death of the person, the State will receive all amounts remaining in the trust up to an amount equal to the total medical assistance paid on the person's behalf.

To be valid, the irrevocable assignment of ownership of the insurance policy must be acknowledged by the insurance company. If the irrevocable assignment is not acknowledged by the life insurance company, treat the policy as the customer's policy. If the face value is greater than $1,500, apply the cash value of the policy to the customer's resource limit (see **PM 07-02-07**).

# PM 07-02-08-c: Irrevocable Prepaid Burial Contract

**WAG 07-02-08-c**

Money in an irrevocable prepaid burial contract with a funeral home cannot be withdrawn. The prepaid burial contract must show that the contract is irrevocable.

The exempt amount is limited to the price of funeral goods and services to be provided upon death as specified in the contract. The contract must include a complete description of the funeral goods and services to be provided, and the price of those goods and services. Treat any amount not specified in the contract as a transfer for less than fair market value.

Exempt ➡$6,562, adjusted annually for any increase in the Consumer Price Index (CPI), in an irrevocable prepaid burial contract. In addition to the ➡$6,562 prepaid burial limit for an irrevocable contract, also exempt all amounts designated for burial space, regardless of value (as defined in **PM 07-02-09**). Apply any remaining amount to the customer's resource limit.

# PM 15-04-04: Use of Income (NH, SLF, and DoA HCBS Waiver)

**WAG 15-04-04**

## Income of LTC spouse and community spouse

The LTC customer and the community spouse are required to provide essential information regarding the total value of income and resources owned by either spouse or both spouses. They must also consent to verification of income and resources; however, beginning with the first full month that a person is a nursing home (NH) resident, SLF resident, or applies for or receives services through the DoA HCBS waiver, the community spouse's income is not considered available to meet the needs of the person.

The payment of nonexempt income from any source (including income from a trust) is considered available to the person and his/her community spouse as follows:

- nonexempt income paid solely to one spouse is considered available only to that person;
- if income is paid to both spouses, 1/2 is considered available to each; or
- if income is paid in the names of one or both spouses **and** to another person(s), the income is considered available to each spouse in proportion to his/her share.

If the customer can prove that the ownership interests in income are different than those listed above, use that proportion.

## Two-step eligibility process

A two-step process is used for financial eligibility determination and income budgeting for LTC customers. The initial step determines financial eligibility for medical assistance using the AABD community medical standard. After eligibility has been established, including meeting spenddown if applicable, income is budgeted in a second step.

### Step 1: Determine eligibility using the AABD community medical standard

Determine financial eligibility for a resident of an NH or SLF by comparing non-exempt income, minus the $25 income exemption and any earned income exemption or employment expenses, to the AABD community standard for one person. Use a one-month eligibility period. Resources are **not** used in this step.

- If non-exempt income after exemptions is **less than or equal to** the AABD community standard, the person is eligible with a regular (non-spenddown) case. Proceed to **Step 2** to budget income.
- If non-exempt income after exemptions **exceeds** the AABD community standard, the case is spenddown. The amount of the spenddown liability is the difference between non-exempt income after exemptions and the AABD community standard. LTC charges anticipated for the month can be applied to meet the spenddown.

- If anticipated LTC charges for the month➡, plus any other applicable medical expenses, meet or exceed the spenddown liability amount, spenddown is met and the person is financially eligible. Proceed to **Step 2** to budget income.
- If anticipated LTC charges for the month➡, plus any other applicable medical expenses, total less than the spenddown liability amount, spenddown is not met and the person is not financially eligible. Enroll as an unmet spenddown case; do **not** budget income in Step 2.

## Step 2: Budget income using LTC deductions (post-eligibility budgeting)

**After** eligibility has been established in Step 1, determine the person's **total** countable income:

- The total gross non-exempt income used in Step 1; **plus**
- Any **exempt or disregarded income** which was **not** used in determining eligibility in Step 1.

From this total, subtract applicable deductions listed below and any allowable medical expenses, to determine countable income. Add to this any non-exempt resources above the resource disregard to determine the amount the person owes to the facility.

Do **not** use the $25 income exemption.

Deduct the following, if applicable, ➡in the order listed:

- ➡employment expenses and the earned income disregard for employed individuals;
- ➡personal needs allowance (NH/SLF standard or veteran benefit disregard);
- CSMNA;
- FMNA ➡(includes minor or dependent children, dependent parents and dependent siblings of the LTC spouse or the community spouse who reside with the community spouse);
- SMIB, medical premiums, deductibles, coinsurance ➡or other non-covered medical expenses (limited to expenses allowed according to **PM 15-08-05**);
- court-ordered support/medical expenses;
- ➡voluntary support; and
- maintenance for community residence.

# PM 15-05-04: Nursing Home/Supportive Living Facility Cases

**WAG 15-05-04.**

To determine countable monthly income for an NH or SLF case, deduct the following items in the order listed from the person's total nonexempt monthly income:

- for a nursing home case, $30 ➡NH (nursing home) Standard or $90 Veterans Benefit Disregard, whichever is appropriate (see **PM 15-04-04-e**);
- for a SLF case, the appropriate SLF Standard (see **PM 15-06-02**);
- Community Spouse Maintenance Needs Allowance; deduct from non-SSI income only (see **PM 15-04-04-a**);
- Family Maintenance Needs Allowance; deduct from non-SSI income only (see **PM 15-04-04-b);**
- Maintenance for Dependent Child(ren) under age 21 who does not reside with the community spouse; deduct from non-SSI income only (see **PM 15-04-04-c**);
- for an NH case, Community Home Maintenance Allowance (see **PM 15-04-04-d**);
- ➡ employment expenses and the earned income disregard for employed individuals;
- SMIB and other health insurance premiums, deductibles, or coinsurance charges;
- other allowable medical expenses (bills and receipts) (see **PM 15-08-06**).

**NOTE:** A receipt for payment of NH and SLF charges at the private pay rate **can only** be applied to a customer's credit or spenddown in the month the payment is made.

Deducting the amounts listed above from total nonexempt income determines the countable monthly income available to apply to NH or SLF care. If the person has excess nonexempt assets, the excess amount is added to the person's countable monthly income to apply to NH or SLF care.

IDHS Illinois Department of Human Services
Grace B. Hou, Secretary

# PM 15-08-14: Nursing Home/Supportive Living Facility Cases

**WAG 15-08-14**

When determining **countable monthly income** to apply to NH or SLF costs, deduct the following amounts from the customer's total nonexempt monthly income:

- for a nursing home (NH) case, $30 NH Standard or $90 Veterans Benefit Disregard, whichever is appropriate (see **PM 15-04-04-e**);
- for an SLF case, the appropriate SLF Standard (see **PM 15-06-02**);
- Community Spouse Maintenance Needs Allowance, deduct from non-SSI income only (see **PM 15-04-04-a**);
- Family Maintenance Needs Allowance, deduct from non-SSI income only (see **PM 15-04-04-b**);
- Maintenance for Dependent Child(ren) under age 21 who does not reside with the community spouse, deduct from non-SSI income only (see **PM 15-04-04-c**);
- for an NH case, Community Home Maintenance Allowance (see **PM 15-04-04-d**);
- ➧ employment expenses and the earned income disregard for employed individuals;
- SMIB and other health insurance premiums, deductibles, or coinsurance charges;
- ➧ court-ordered child support, alimony payments, legal fees; and
- other allowable medical expenses (bills and receipts) (see **PM 15-08-05** through **PM 15-08-07**).

Deducting the amounts listed above from total nonexempt income determines countable monthly income available to apply to NH or SLF care. If the person has excess nonexempt assets, the excess amount is added to the person's countable monthly income and applied to NH or SLF care.

**NOTE:** ➧A receipt for payment of NH and SLF charges at the private pay rate can only be applied to a person's credit or spenddown in the month the payment is made.

IDHS Illinois Department of Human Services
Grace B. Hou, Secretary

# PM 15-06-02-b: NH Personal Needs Allowance/SLP Room and Board Amount

**WAG 15-06-02-b**

The Nursing Home (NH) Personal Needs Allowance (PNA) is $30. This allowance can be different for certain veterans or surviving spouses who are nursing home residents (see **PM 15-04-04-e**).

The Room and Board Amount for a resident of a Supportive Living Program (SLP) is based on whether the person shares a room. For an SLP resident who does not share a room, the Room and Board Amount is the SSI rate for a single person and 1/2 of the SSI rate for a couple. For ➡2017, the Room and Board Amount for a single person is ➡$735 and ➡$551.50 for a couple.

IDHS Illinois Department of Human Services
Grace B. Hou, Secretary

# WAG 25-03-02 (2)



## Program Standards

### Family Health Plans - 1 *

| # in unit | Family Assist ➡ Effective 10/1/18 | Family Health Spenddown | All Kids Assist ➡Updated for 2019 MAGI - 147% FPL (includes 5% disregard) (Children) | FamilyCare and ACA Adults ➡Updated for 2019 MAGI - 138% FPL (includes 5% disregard) (Adults) |
|---|---|---|---|---|
| **1** | $304 | $283 | $1,530 | $1,436 |
| **2** | 412 | 375 | 2,071 | 1,945 |
| **3** | 520 | 508 | 2,613 | 2,453 |
| **4** | 628 | 558 | 3,154 | 2,961 |
| **5** | 736 | 650 | 3,696 | 3,470 |
| **6** | 844 | 733 | 4,237 | 3,978 |
| **7** | 952 | 767 | 4,779 | 4,486 |
| **8** | 1060 | 808 | 5,320 | 4,994 |
| **9** | 1168 | 850 | 5,861 | 5,502 |
| **10** | 1276 | 900 | 6,402 | 6,010 |
| **Each add'l** | | +67 | +541 | +508 |

### Family Health Plans - 2 *

➡**2019 Income Standards**

| # in unit | All Kids Share<br>MAGI - Over 147% up to 157% FPL<br>(Children) | All Kids Premium Level 1<br>MAGI - Over 157% up to 209% FPL<br>(Children) | Moms & Babies<br>MAGI - 213% FPL<br>(includes 5% disregard) |
|---|---|---|---|
| 1 | $1,531 - 1,634 | $1,635 - 2,175 | --- |
| 2 | 2,072- 2,212 | 2,213 - 2,945 | $3,002 |
| 3 | 2,614 - 2,791 | 2,792 - 3,715 | 3,786 |
| 4 | 3,155 - 3,369 | 3,370 - 4,485 | 4,571 |
| 5 | 3,697 - 3,947 | 3,948 - 5,255 | 5,355 |
| 6 | 4,238 - 4,526 | 4,527 - 6,024 | 6,140 |
| 7 | 4,780 - 5,104 | 5,105 - 6,794 | 6,924 |
| 8 | 5,321 - 5,682 | 5,683 - 7,564 | 7,709 |
| 9 | 5,862 - 6,260 | 6,261 - 8,334 | 8,494 |
| 10 | 6,403 - 6,838 | 6,839 - 9,104 | 9,279 |
| Each add'l. | + 578 | + 770 | + 785 |

## ➧2019 Income Standard for MPE

| Family Size | Monthly Income |
|---|---|
| 2 | $3,002 |
| 3 | 3,786 |
| 4 | 4,571 |
| 5 | 5,355 |
| 6 | 6,140 |
| 7 | 6,924 |
| 8 | 7,709 |
| 9 | 8,494 |
| each additional person | +785 |

## Threshold at Which a Child or Tax Dependent is Expected to be Required to File a Tax Return (MAGI)

Use "last year's" tax information. The table below is updated for 2019.

| Tax Year | 2014 | 2015 | 2016 | 2017 | ➧2018 |
|---|---|---|---|---|---|
| Monthly Earned Income | $508 | $517 | $525 | $529 | $1,000 |
| Monthly Unearned Income* | 83 | 83 | 87 | 88 | 88 |

*Excluding SSA Income. See **PM 15-06-01-h**.

## MAGI Deduction Limits

The MAGI deductions listed below are the ones with limits. To see all of the MAGI deductions, go to **PM 08-03-03**.

| **MAGI Deductions that are Limited** | **Year 2019** ➡ |
|---|---|
| **Health Savings Account contribution limit** | Single person: $291 per month<br>Family: $583 per month |
| **Moving expense limit** | The new workplace must be 50 miles or more further from the person's old home. |
| **Student loan interest limit** | $2,500 in a tax year. Certain rules apply-see **PM 08-03-03**. |
| **Educator Expense** | Single Person: $250 per year<br>Family: $500 per year |
| **IRA Deduction** | Age: less than 50: $6,000<br>greater than 50: $7,000 |
| **Home Equity Limit** | $585,000 per year. |
| **Tuition and fees limit** | $4,000 per year. Annual MAGI income cannot be more than $80,000 for single or $160,000 for a joint return. **Tuition and Fees are no longer considered an allowable deduction as of 1/1/2018.** |

## AABD Medical/Medicare Savings Programs/HBWD

**➡2019 Income Standards**

| **# in unit** | **AABD/QMB 100% FPL** | **SLIB**<br>**Over 100% to less than 120%** | **QI-1**<br>**120% to less than 135% FPL** | **HBWD (LO 250)**<br>**Less than or Equal to 350% FPL** |
|---|---|---|---|---|
| **1** | $1,041 | $1,042 - 1,248 | $1,249 - 1,404 | $3,643 |
| **2** | 1,409 | 1,410 - 1,690 | 1,691 - 1,901 | 4,932 |
| **3** | 1,778 | 1,779 - 2,132 | 2,133 - 2,399 | 6,221 |
| **4** | 2,146 | 2,147 - 2,574 | 2,575 - 2,896 | 7,510 |
| **5** | 2,514 | 2,515 - 3,016 | 3,017 - 3,393 | 8,800 |
| **6** | 2,883 | 2,884 - 3,458 | 3,459 - 3,890 | 10,089 |
| **7** | 3,251 | 3,252 - 3,900 | 3,901 - 4,388 | 11,378 |
| **8** | 3,619 | 3,620 - 4,342 | 4,343 - 4,885 | 12,667 |
| **9** | 3,987 | 3,988 - 4,784 | 4,785 - 5,382 | 13,956 |

| # in unit | AABD/QMB 100% FPL | SLIB Over 100% to less than 120% | QI-1 120% to less than 135% FPL | HBWD (LO 250) Less than or Equal to 350% FPL |
|---|---|---|---|---|
| **10** | 4,355 | 4,356 - 5,226 | 5,227 - 5,879 | 15,245 |
| **Each add'l.** | +368 | +442 | +497 | +1,289 |

| ITEM | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|
| **Grant Adjustment** ***Changes in January*** | 531.90 | 542.90 | 554.90 | 554.90 | 556.90 | 571.90 | 592.90 |
| **Spousal Impoverishment** | 109,560 | 109,560 | 109,560 | 109,560 | 109,560 | 109,560 | 109,560 |
| **Resources** | | | | | | | |
| **Spousal Income** | 2,739 | 2,739 | 2,739 | 2,739 | 2,739 | 2,739 | 2,739 |
| **Family Maintenance** | 1,891.25 | 1,938.75 | 1,966.25 | 1,966.25 | 2030.00 | 2,058.00 | 2,058.00 |
| **SLP, Single** | 710 | 721 | 733 | 733 | 735 | 750 | 771 |
| **SLP, Shared Room** | 533 | 541 | 550 | 550 | 551.50 | 562.50 | 578.50 |
| **SSI - Individual** | 710 | 721 | 733 | 733 | 735 | 750 | 771 |
| **SSI - Couple** | 1,066 | 1,082 | 1,100 | 1,100 | 1,103 | 1,125 | 1,157 |

The Medicare Part B premium deduction is based on the individual's income as well as the initial year of enrollment. Check SOLQ to confirm the correct amount for the Medicare Part B premium deduction.

## Resources

| Program | One person | 2 people | More than 2 |
|---|---|---|---|
| **SNAP** | 2,250** | 2,250** | 2,250** |
| **AABD Cash/Medical** | 2,000 | 3,000 | Add 50 for each additional. |
| **Medicare Savings Programs** | 7,080 (2013)<br>7,160 (2014)<br>7,280 (2015)<br>7,280 (2016)<br>7,390 (2017) | 10,620 (2013)<br>10,750 (2014)<br>10,930 (2015)<br>10,930 (2016)<br>11,090 (2017) | 10,620 (2013)<br>10,750 (2014)<br>10,930 (2015)<br>10,930 (2016)<br>11,090 (2017)<br>11,340 (2018)<br>11,600 (2019) |

| Program | One person | 2 people | More than 2 |
|---|---|---|---|
| | 7,560 (2018) | 11,340 (2018) | |
| | ➡7,730 (2019) | 11,600 (2019) | |
| **HBWD** | 25,000 | 25,000 | 25,000 |
| **(see PM 06-24-05)** | | | |

***Family Health Plans & TANF** - Resources not considered.

*➡*3,500 if at least one person is a qualifying member (see **PM 07-04**).